MEMORANDUM OF UNDERSTANDING
WORKERS' COMPENSATION PROGRAM

This Memorandum of Understanding is entered into by and between the CSAC Excess Insurance Authority (hereinafter referred to as the "Authority") and the participating counties who are signatories to this Memorandum.

1. **Joint Powers Agreement.** Except as otherwise provided herein, all terms used herein shall be as defined in Article 1 of the Joint Powers Agreement Creating the CSAC Excess Insurance Authority (hereinafter referred to as "Agreement"), and all other provisions of the Agreement not in conflict with this Memorandum shall be applicable.

2. **Annual Premium.** The participating counties, in accordance with the provisions of Article 14(b)(2) of the Agreement, shall be assessed an annual premium for the purpose of funding the Workers' Compensation Program (hereinafter referred to as the "Program"). Annual premiums shall include expected losses for the policy period, including incurred but not reported losses (IBNR), as well as a margin for contingencies based upon a confidence level as determined by the Board of Directors of the Authority (hereinafter Board), and adjustments, if any, for a surplus or deficit from all program policy periods. In addition, the premium shall include program reinsurance costs and program administrative costs, plus the Authority's general expense allocated to the Program by the Board for the next policy period.

3. **Cost Allocation.** Each participating county's share of annual premium shall be determined pursuant to a cost allocation plan as described in Article 14(b)(2) of the Agreement. The Board approved cost allocation plan is attached hereto as Exhibit A and may be amended from time to time by an affirmative vote of the majority of the Board representing the counties participating in the Program.

4. **Dividends and Assessments.** The Program shall be funded in accordance with paragraph 2 above. In general, the annual premium, as determined by the Board, will be established at a level which will provide adequate overall funding without the need for adjustments to past policy period(s) in the form of dividends and assessments. However, should the Program for any reason not be adequately funded, except as otherwise provided herein, pro-rata assessments to the participating counties may be utilized to ensure the approved funding level for those policy periods individually or for a block of policy periods, in accordance with the provisions of Article 14(b)(3) of the Agreement. Pro-rata dividends will be declared as provided herein. Dividends may also be declared as deemed appropriate by the Board.

5. **Closure of Policy Periods.** Notwithstanding any other provision of this Memorandum, the following provisions are applicable:

(a) Upon reaching ten (10) years of maturity after the end of a program period, that period shall be "closed" and there shall be no further dividends declared or assessments made with respect to those program periods except as set forth in paragraphs 6(a) and 6(b), below;

(b) Notwithstanding sub-paragraph (a) above, the Board may take action to leave a policy period "open" even though it may otherwise qualify for closure. In addition, the last ten (10) policy periods shall always remain "open" unless the Board takes specific action to declare any of the last ten (10) policy periods closed.

(c) Dividends and assessments (other than as outlined in paragraphs 6(a) and 6(b), below) shall be administered to the participating counties based upon the proportion of premiums paid to the Program in "open" periods only. For purposes of administering dividends and assessments pursuant to this sub-paragraph, all "open" policy periods shall be considered as one block.

6. **Declaration of Dividends.** Dividends shall be payable from the Program to a participating county in accordance with its proportionate funding to the Program during the applicable program period as follows:

(a) A dividend shall be declared at the time a program period is closed on all amounts over the 90% confidence level;

(b) A dividend shall be declared at the time a program period is closed on all amounts which represent premium surcharge amounts assessed pursuant to Article 14(b)(3) of the Agreement where the funding exceeds the 80% confidence level.

7. **Memorandum of Coverage.** A Memorandum of Coverage will be issued by the Authority evidencing membership in the Program and setting forth terms and conditions of coverage.

8. **Disputes.** Any question or dispute with respect to the rights and obligations of the parties to this memorandum regarding coverage shall be determined by a majority vote of the Board.

9. **Amendment.** This Memorandum may be amended by two-thirds of the CSAC Excess Insurance Authority's Board of Directors upon ninety (90) days' advance written notice to the Member Counties and their respective counsels specifying the proposed amendments.

10. **Complete Agreement.** Except as otherwise provided herein, this Memorandum constitutes the full and complete agreement of the members.

11. **Severability.** Should any provision of this Memorandum be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.

12. **Effective Date.** This Memorandum became effective on July 1, 1993 as it relates to participating counties and shall be effective on the first day of coverage as it relates to the County of _____.

13. **Execution in Counterparts.** This Memorandum may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

IN WITNESS WHEREOF, the undersigned have executed this Memorandum as of the date set forth below.

Dated: _____

_____
CSAC Excess Insurance Authority

Dated: _____

_____
County of _____

EXHIBIT A

EXCESS WORKERS' COMPENSATION PROGRAM
COST ALLOCATION PLAN

As delegated by the Board of Directors, the Executive Committee will determine the specific allocation of all costs among the members subject to the following parameters:

Actuarial Analysis

An annual actuarial analysis will be performed using loss data and payroll collected from the members. The analysis will determine the necessary funding rates at various confidence levels and using various discount assumptions. Different rates may be developed for different groups or classes of business as is deemed necessary or appropriate by the Executive Committee. At the March Board meeting, the Board of Directors will select the funding level rates and discount factors to be used based upon the actuarial analysis and recommendations from the actuary, the Underwriting Committee and the Executive Committee.

Pool Contributions

The total needed deposit pool contribution will be determined by multiplying the rates described above by the payroll for all of the members participating in the pool. Estimated payroll for the year being funded will be used. The Executive Committee may break the pool into different layers for allocation purposes, and may apply a different loss experience modification for each layer as is deemed appropriate based on loss frequency. In general, the lower layers will be subject to greater experience modification and the higher layers will be subject to lower experience modification or no experience modification. Within the layers, the larger members will be subject to greater experience modification than the smaller members. After the experience modification has been applied for each layer, there will be a pro-rata adjustment back to the total needed deposit pool contribution. This amount will be collected from the members at the beginning of the policy period. The actual payroll for the period will be determined after the completion of the policy period and an adjustment to each member's pool contribution will be made to account for the difference between the estimated and actual payroll. Additional contributions will be collected or return contributions will be refunded as appropriate.

Reinsurance Premiums

The reinsurance premium will be determined through negotiations with the reinsurer(s) and approved by the Board upon recommendation of the Underwriting and Executive Committees. This premium will then be allocated

among the members based upon their estimated payroll. Adjustments will be made based on the actual payroll upon completion of the policy period in the same manner as described in the Pool Contribution section above.

EIA Administration Fees

The total EIA Administration Fees will be determined through the annual budgeting process with an appropriate amount allocated to the Excess Workers' Compensation Program. These fees will be allocated among the members as determined by the Executive Committee. In general, the basis for this allocation will be each member's percentage of the total pool contributions and reinsurance premium.

Deviation From the Standard

The Executive Committee may establish policies to deviate from the standard allocation methodology selected for each year on a case-by-case basis, if necessary. They may also elect to further delegate some or all of the decision-making authority described herein to the Underwriting Committee.

SCHEDULE OF POLICY PERIODS

Policy Period	Pooled Layer of Coverage
November 1, 1979-80	Pool from SIR to $500,000
November 1, 1980-81	Pool from SIR to $500,000
November 1, 1981-82	Pool from SIR to $500,000
November 1, 1982-83	Pool from SIR to $500,000
November 1, 1983-84	Pool from SIR to $500,000
November 1, 1984-85	Pool from SIR to $500,000
November 1, 1985-86	Pool from SIR to $500,000
November 1, 1986-87	Pool from SIR to $500,000
November 1, 1987-88	Pool from SIR to $500,000
November 1, 1988 - July 1, 1989	Pool from SIR to $500,000
July 1, 1989-90	Pool from SIR to $500,000
July 1, 1990-91	Pool from SIR to $500,000
July 1, 1991-92	Pool from SIR to $500,000
July 1, 1992-93	Pool from SIR to $500,000
July 1, 1993-94	Pool from SIR to $500,000 (07/01/93-10/05/93) Pool from SIR to $750,000 (10/05/93-07/01/94)
July 1, 1994-95	Pool from SIR to $750,000 (07/01/94-01/01/95) Pool from SIR to $300,000 (01/01/95-07/01/95)
July 1, 1995-96	Pool from SIR to $300,000
July 1, 1996-97	Pool from SIR to $300,000
November 1, 1986-88	AOD Pool excess of $500,000
November 1, 1988 - July 1, 1991	AOD Pool excess of $500,000
July 1, 1991-October 5, 1993	AOD Pool excess of $500,000

Adopted: December 6, 1985
Amended: January 23, 1987
Amended: October 6, 1995
Amended: October 1, 1999
Amended: October 3, 2003

CSAC EXCESS INSURANCE AUTHORITY

UNDERWRITING AND CLAIMS ADMINISTRATION STANDARDS

I. GENERAL

A. Each Member shall appoint an official or employee of the Member to be responsible for the risk management function and to serve as a liaison between the Member and the Authority for all matters relating to risk management.

B. Each Member shall maintain a loss prevention program and shall consider and act upon all recommendations of the Authority concerning the reduction of unsafe conditions.

C. Each Member shall maintain records of claims in each category of insurance covered by a program of the Authority and shall provide copies of such records to the Authority as directed by the Executive, Underwriting or Claims Review Committees.

Such records shall provide the following information by fiscal year: number of claims (open and closed); amounts paid, amounts reserved and total incurred. Allocated expenses shall be included. If losses are capped, the excess amount shall be indicated.

II. EXCESS WORKERS' COMPENSATION PROGRAM

A. The Member shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its workers' compensation claims. At least one person in the claims office (whether in-house or outside administrator) shall be certified by the State of California as a qualified administrator of self -insured workers' compensation plans.

2. Qualified defense counsel experienced in workers' compensation law and practice shall handle litigated claims.

Members are encouraged to utilize attorneys who have the designation "Certified Workers' Compensation Specialist, the State Bar of California, Board of Legal Specialization".

3. The Member shall use the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) and shall advise its claims administrator that these guidelines are utilized in the Authority's workers' compensation claims audits.

B. The Member shall provide the Authority written notice of any potential excess workers' compensation claims in accordance with the requirements of the Authority's bylaws. Updates on such claims shall be provided as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claim experience or number of large claims or

2. There is a change of workers' compensation claims administration firms or

3. The Member is a new member of the Excess Insurance Authority.

The claims audit shall be performed by a firm selected by the Authority. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three- (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

III. EXCESS LIABILITY PROGRAMS

A. The Member shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its liability claims.

2. Qualified defense counsel experienced in tort liability law shall handle litigated claims. Members are encouraged to utilize defense counsel experienced in the subject at issue in the litigation.

3. The Member shall use the Liability Claims Administration Guidelines (Addendum B) and shall advise its claims administrator that these guidelines be utilized in the Authority's liability claims audits.

B. The Member shall provide the Authority written notice of any potential excess liability claim in accordance with the requirements of the Authority's bylaws. Updates on such claims shall be provided as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Liability Claims Administration Guidelines (Addendum B) shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claims experience or number of large claims or

2. There is a change of liability claims administration firms or

3. The Member is a new member of the Excess Insurance Authority.

The claims audit shall be performed by a firm selected by the Authority. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three- (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or

exceeding the present value of expected losses and a reasonable margin for contingencies.

IV. PROPERTY PROGRAMS

A. The Member shall maintain appropriate records including a complete list of insured locations and schedule of values pertaining to all real property. Copies of such records shall be provided to the Authority or its brokers as requested by the Executive or Property Committees.

B. Each Member shall perform a real property replacement valuation for all locations over one million dollars. Valuations shall be equivalent to the Marshall Swift system and shall be performed at least once every five- (5) years. New members shall have an appraisal or valuation performed within one year from entry into the program.

V. MEDICAL MALPRACTICE PROGRAM

A. The Member, if a member of Medical Malpractice Program I (hereinafter Program I), or Mid Mal Program; or the third party administrator for Medical Malpractice Program II (hereinafter Program II); shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member (Program I and Mid Mal Program) or third party administrator (Program II) shall use only qualified personnel to administer its health facility claims.

2. Qualified defense counsel experienced in health facility law shall handle litigated claims.

3. The Member (Program I and Mid Mal Program) or third party administrator (Program II) shall use the "Claims Reporting And Handling Guidelines" in the CSAC/Excess Insurance Authority Medical Malpractice Excess Insurance Program Operating And Guidelines Manual (hereinafter OPERATING AND GUIDELINES MANUAL), and shall advise its claims administrator that these claims handling guidelines are utilized in the Authority's medical malpractice claims audits.

B. The Member (Program I and Mid Mal Program) or third party administrator (Program II) shall provide the Authority and its excess carrier written notice of any potential excess claim or "major incident"

in accordance with the requirements of the Authority and of the excess carrier as stated in the OPERATING AND GUIDELINES MANUAL. Updates on such claims or major incidents shall be provided as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Claims Reporting and Handing Guidelines in the OPERATING AND GUIDELINES MANUAL shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claims experience or number of large claims or

2. There is a change of health facility claims administration firms or

3. The Member is a new member of the Excess Insurance Authority or

4. The Medical Malpractice Committee requests an audit.

The claims audit shall be performed by a firm selected by the Authority. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. If a Member of Program I or the Mid Mal Program, the Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

E. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as states in the OPERATING AND GUIDELINES MANUAL.

VI. SANCTIONS

A. The Authority shall provide the Member written notification of the Member's failure to meet any of the above-mentioned standards or of other concerns, which affect or could affect the Authority.

B. The Member shall provide a written response outlining a program for corrective action within sixty (60) days of receipt of the Authority's notification.

C. After approval by the Executive Committee of the Member's corrective program, the Member shall implement the approved program within ninety (90) days. The Member may request an additional sixty (60) days from the Executive Committee. Further requests for extensions shall be referred to the Board of Directors.

D. Failure to comply with subsections B or C may result in cancellation of the Member from the affected Authority insurance program in accordance with the provisions in the Joint Powers Agreement.

E. Notwithstanding any other provision herein, any Member may be canceled pursuant to the provision of the Joint Powers Agreement.